Working Spouse Verification
2015 Plan Year
(Revised October 4, 2014)

Participation in the City of Memphis Medical Plan is limited to full time employees and eligible dependents. A spouse is an eligible dependent and may participate in the City's plan, however, if your spouse has access to insurance through his/her employer and that spouse is a participant in the City's plan, a $100 surcharge per month is applicable unless the City's plan is secondary.

Please complete this Verification and return it with your enrollment materials. If you do not return the Verification, and your spouse is a covered dependent in the City's plan the $100 surcharge per month is applicable. The surcharge may be removed only during an open enrollment period or within 60 days of your spouse becoming ineligible for insurance through his/her current employer.

Employee Name: _____ Employee Last 4 of SSN: _____
(Last, First, MI)

Spouse Name: _____ Spouse Last 4 of SSN: _____
(Last, First, MI)

Please read all options and initial the appropriate response:

_____ The spouse listed above is employed by the City of Memphis.

_____ The spouse listed above does not have medical insurance available through a current employer, a previous employer and is not currently eligible for Medicare.

_____ The spouse listed above is employed/retired but not eligible for group medical coverage through his/her own employer. My spouse is employed at _____.

_____ The spouse listed above is employed or retired and eligible for medical coverage through his/her own employer or Medicare. My spouse is employed at _____. **(Choose the appropriate response below):**

_____My spouse DOES NOT participate in his/her employer's medical plan or Medicare. (The $100 per month surcharge is applicable).

_____My spouse DOES participate in his/her employer's medical plan but that plan is secondary and the City's medical plan is primary. (The $100 per month surcharge is applicable).

_____My spouse DOES participate in his/her employer's medical plan or Medicare and that plan is primary and the City's plan is secondary. (The surcharge is not applicable).

The undersigned do hereby attest that the above information is true and correct to the best of my knowledge. We acknowledge the City of Memphis reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Verification. The undersigned also understand that if my spouse's group medical insurance status changes, it is my responsibility to notify the Benefits Office within 60 days of such change. We further acknowledge that if the spouse listed above is covered under the City of Memphis medical plan and the spousal surcharge has not been paid when required, that we may be required to repay the cost of any claims incurred or paid under the City's Medical Plan. We further understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in disciplinary action up to and including termination of employment.

Signature _____ Date _____
Employee

Signature _____ Date _____
Spouse